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CLEARINGHOUSE

Progress Through Partnership

Medicaid
Medicare
Management Institute

MEDICAID MEDICARE EXCHANGE

OCTOBER, 1979 ISSUE #1

WELCOME TO OUR READERS . . .

The Medicaid/Medicare Management Institute (MMMI) invites you to peruse the first issue of the Medicaid/Medicare Exchange. As many of you know, the Health Care Financing Administration expanded the role of the former Institute for Medicaid Management to address concerns of both the Medicare and Medicaid programs. To reflect this expanded role of the new Medicaid/Medicare Management Institute, publications have been redesignated and revised. In the next few weeks, you will see the first issue of Perspectives on Medicaid and Medicare Management, a compilation of articles reflecting varied approaches to program management. Both Perspectives and the MMX will feature management information pertinent to HCFA's two health care programs. Both will be targeted for the staff involved in administering Medicare and Medicaid - at Federal, State and Medicare contractor levels.

In this initial issue, the MMX focuses on Medicare management information. Late-breaking Medicaid news may be found in these pages as well. In future, MMX will alternate its focus between Medicare and Medicaid news.

The MMX is a quick and informal means for HCFA to communicate with State Medicaid agencies, Medicare carriers and intermediaries, and others interested in Medicare and Medicaid programs. The MMX will notify you of conferences, pending legislation, policy changes, and personnel changes on a timely basis. Through the MMX, State Medicaid agencies can communicate with each other, to share highlights of experiences and management problems and techniques. The MMX will inform Medicare contractors of various demonstration projects and Regional efforts of interest. The MMX is a cooperative effort between the Institute and its readers. We hope you will submit items for publication.

For further information about the MMX, contact Editor Elaine Blackman. Questions regarding other publications can be directed to Ginger Hale, Chief of the Improvements Information Branch. Suggestions for both publications are welcomed.

Mary Kenesson

Mary Kenesson
Director
Medicaid/Medicare
Management Institute

MEDICAID/MEDICARE COORDINATION EFFORTS IN REGION VI

Through the efforts of HCFA's Region VI office, executive committees of top staff from State Medicaid agencies, and Medicare and Medicaid contractors have been formed to coordinate Medicare/Medicaid projects.

Purpose of the State committees is to promote coordination between Medicare and Medicaid, identify worthwhile Medicare/Medicaid projects, prioritize projects and monitor project progress. Through the committees, commitment to such projects is assured, as is staff to carry out the tasks.

Premiere meetings of each committee occurred early this summer; at that time, committee composition was determined, projects were selected and subcommittees set up for each project. A monthly reporting system was also established for each project. Current Medicare/Medicaid projects by States are:

Arkansas -- install paperless billing systems in hospitals and clinics, including use of the system for transmitting PSRO abstracts; conduct joint workshops for provider personnel on claims completion; design and implement an integrated postpayment review system.

Louisiana -- uniform conversion to and implementation of International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnostic coding; explore feasibility of common Medicare/Medicaid provider identification numbers; joint workshops for provider personnel on claims completion; efficient and timely transfer of claims information between Medicare and Medicaid claims processing agents, including implementing a common physician claims form for Medicare, Medicaid and Blue Shield; explore designing and implementing a common hospital billing form; and install electronic billing systems for all hospitals and clinics.

New Mexico -- install paperless billing in all hospitals and clinics; conduct joint workshops for provider personnel on claims completion; conversion to ICD-9-CM diagnostic coding.

Oklahoma -- joint workshops for provider personnel on completion of claims; design a common type format for Medicare and Medicaid hospital billings; develop a common format for Medicare and Medicaid physician claims.

Texas -- install electronic billing systems in hospitals and clinics throughout the State; efficient and timely transfer of claims information between Medicare and Medicaid in misdirected claims cases; conversion to ICD-9-CM diagnostic coding.

Projects are proceeding on schedule, reports Regional Administrator Jerry D. Sconce, with significant progress being made (in Louisiana and New Mexico) on the joint workshops.

COMMON CLAIM FORM

HCFA is developing a revised common claim form for the Medicaid and Medicare programs. A single form will combine common data elements and include required data needs for multiple users, thus reducing time and effort in completing claims forms. HCFA's revised form is based on the Health Insurance Claim form, previously developed under the auspices of the AMA.

If the Administrator approves the form, HCFA's Office of Methods and Systems can move forward with plans to finalize, print and distribute the form to physicians/suppliers.

REGULATION REVIEW

Following are several recent HCFA regulations of special interest to Medicare and Medicaid program managers. Questions may be directed to the contact person listed with each regulation.

- Schedule of limits on SNF inpatient routine service costs - correction

  9/13/79 Federal Register - refers to 8/31/79 Federal Register

- Schedule of limits on SNF inpatient routine service costs - final notice

  8/31/79 Federal Register - effective date 10/1/79
  Contact: Mr. Carl Slutter (301) 594-9344
  FTS 8-934-9344

- Medicare reimbursement for cost of approved internship and residency programs - proposed rule

  8/10/79 Federal Register; comments due 10/9/79
  Contact: Mr. William Goeller (301) 597-2886
  FTS 8-987-2886

- Medical Assistance Program; Family planning services - proposed rule

  8/9/79 Federal Register; comments due 10/9/79
  Contact: Margaret O. Schnoor (202) 245-0624

- Limiting reimbursement for provider costs and for services by hospital based physicians; direct apportionment of malpractice costs to Medicare - final rule

  6/1/79 Federal Register - effective date 7/1/79
  Contact: Hugh McConville (301) 594-9682
  FTS 8-934-9682

- Medicare Program; Initial schedule of limits on home health agency costs per visit for cost reporting period beginning on or after July 1, 1979 - final notice

  6/1/79 Federal Register - effective date 7/1/79
  Contact: Mr. Carl Slutter (301) 594-9344
  FTS 8-934-9344

- Medicare Program; Schedule of limits on hospital in-patient general routine operating costs for cost reporting period beginning on or after July 1,1979 - final notice

  6/1/79 Federal Register - effective date 7/1/79
  Contact: Mr. Carl Slutter (301) 594-9344
  FTS 8-934-9344

HCFA/CIVIL RIGHTS AGREEMENT

HCFA and the Office of Civil Rights (OCR) entered into a memorandum of understanding on civil rights enforcement and responsibilities July 27. The agreement covers HCFA's civil rights plans for all its programs and requires HCFA to achieve objectives of the civil rights statutes -- Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. The agreement evolved from HEW Secretarial policy of making civil rights an essential and integral part of every department program.

Among the HCFA responsibilities specified in this agreement are: assuring, through program audit and review, that Medicare and Medicaid benefits and services are received by eligible beneficiaries; establishing or adopting systems for collecting data on minority and handicapped persons' participation in HCFA programs; reviewing program regulations, directives and instructions to assure support for the department's civil rights authorities; and initiating orientation and training programs on civil rights requirements for HCFA staff and beneficiaries.

Some of the OCR responsibilities specified in this agreement include: developing civil rights standards and procedures for HCFA program audits and reviews; developing guidelines for systems HCFA will establish to collect and review data to identify civil rights' compliance problems; conducting training programs to carry out HCFA's civil rights responsibilities; designing and proposing a HCFA civil rights activity reporting system; and coordinating the development of a HCFA Civil Rights Operating Plan.

HCFA regional offices, the Health Standards and Quality Bureau (HSQ) and the Bureau of Program Operations (BPO) are responsible for implementing this agreement. Medicaid and HSQ regional office staffs have been trained to conduct Section 504 briefings for HCFA providers and Medicaid State agencies.

Questions concerning HCFA's Civil Rights Plan should be referred to Walter Rutemueller, (301) 594-7955.

SIMPLIFYING BENEFICIARY NOTICES

To make Medicare notices easier for beneficiaries to read and understand, HCFA central office staff are working with State Medicaid representatives in revising Explanation of Medicare Benefits (EOMB) forms. This is an integrated effort to establish universal terms applicable to both programs.

HCFA's Office of Methods and Systems plans to test one approach in November with a sampling of beneficiaries. An EOMB form resembling a letter, with information tailored for each individual case, will be sent to the sample population. Beneficiary reactions will determine final specifications of the form. HCFA's goal is to provide specific information in simple, brief terms to its program beneficiaries.

HCFA UTILIZATION SCREENS PROJECT

HCFA is working on a project to improve the medical necessity and utilization screens in the Title XVIII and Title XIX programs. The goal of the project is to furnish contractors with clear guidelines on postpayment and prepayment screens on medical necessity and utilization control. The final project will also provide for the maintenance and periodic assessment of these screens.

For several years, the Medicare program has required its carriers to perform certain minimum prepayment and postpayment utilization screening. A revised Medicare carrier package, to be published this fall, expands these requirements to include discussion of the carrier's EDP systems capacity and the required prepayment and postpayment reports. New carrier manual instructions which will be part of the carrier package, explain how the requirements should be performed.

In the Medicaid program, the 25 States with certified Medicaid Management Information Systems (MMIS) use the Surveillance and Utilization Review (SUR) subsystem for utilization control. The Medicare program is aware of this; the manual revision is designed only for Medicare carrier use (at this time).

In a broader integrated project now underway, HCFA will establish minimum prepayment and postpayment screens for use by Medicare contractors and Medicaid State Agencies. This project is an outgrowth of the Medicare carrier screens project. Medicaid fiscal agents and PSRO's have participated with Medicare carriers in meetings held to review the carrier screens package. Central office HCFA staff are planning an evaluation of the most effective parts of SUR.

MMMI EVENTS

State Independent Professional Review/ Medical Review Teams Training
November 6-8 - Dallas, TX
Contact: Beulah Williamson
(301) 594-8647
FTS 8-934-8647

Fiscal Intermediary Group Meeting
November 8 - Baltimore, MD
Contact: Paul Beller
(301) 594-9523
FTS 8-934-9523

State Medicaid Directors Mid-Year Conference
November 14-16 - Orlando, FL
Contact: Edward Palder
(301) 594-8940
FTS 8-934-8940

Carrier Representative Group Meeting
November 28-29 - Baltimore, MD
Contact: Paul Beller
(301) 594-9523
FTS 8-934-9523

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Evaluation of the critical indicators in the SUR system will aid in the development of HCFA requirements containing the best aspects of Medicare and Medicaid utilization approaches. The exchange of data among the HCFA contractors and the HCFA regional offices and central office will allow more effective screening of problem utilization areas and potentially aberrant providers of medical service. Further information may be obtained from Mary Anne Durham, Office of Methods and Systems, (301)-594-9866, FTS 8-934-9866.

MEDICARE CASH MANAGEMENT

HCFA's Checks Paid Method minimizes bank service charges and bank balances for Medicare accounts. The system evolved in 1975 in response to OMB initiatives directing all government agencies to devise cash management procedures designed to defer withdrawal of funds from the U.S. Treasury until needed to cover disbursements.

By the end of FY '79, HCFA will have converted almost all Medicare accounts to this method, using letter of credit procedures. Prior to HCFA's inception of this cash management technique during FY '75, the average daily balance in all Medicare bank accounts had reached approximately $82.7 million. Between the inception of this technique and September 30, 1978, the average daily balance in all Medicare bank accounts was reduced to $43.9 million, a reduction of $38.8 million. This was achieved even though Medicare benefit payments and check volumes rose during the same period. Savings to the Health Insurance Trust Fund is equated at $3.2 million in annual interest, computed at the September 1978 Trust Fund 8.25 percent earnings rate.

The Checks Paid Method requires competitive bidding to select banks. The bidding process impacted significantly on minority banks. Under this method, HCFA went from 20 Medicare accounts in 13 minority banks down to five Medicare accounts in three minority banks. To accomodate both the cash management initiatives and to assure continued participation by minority banks, HCFA, in the Fall of 1978, developed and implemented a new, highly successful Medicare Minority Bank Deposit Program.

By October 1, 1979, HCFA will have 20 Medicare accounts currently being serviced by, or awarded to, nine minority banks scattered throughout the country, with total demand and time deposits of approximately $4.2 million. The 20 accounts represent 16.1 percent of Medicare's total accounts, and the $4.2 million represent approximately 9 percent of total Medicare deposits. The basic goal of HCFA's Minority Bank Deposit Program is to maintain current achievements and possibly improve on them.

Additional information about this program and the Checks Paid Method can be obtained from Stephanie Crowley, Office of Program Administration, (301) 597-1391, FTS 8-987-1391.

MEDICARE CARRIER CUTS CHECK SERVICE COSTS

One of Medicare's Part B carriers, Prudential Insurance Company, recently lowered its monthly check service costs by $2,700 per month, reducing the cost per check to under two cents for the 360,000 paid monthly by Prudential in Georgia, North Carolina and New Jersey. Prudential's account was rebid when its former servicing bank asked for a $28,000 monthly increase, triple the then $9,500 monthly service charge. The account was awarded in August, 1979 to the Indiana National Bank, lowest of 16 bidders with a $6,843 bid. This is the lowest price per check ever experienced in Medicare under the Checks Paid Method.

Personnel

MEDICARE

INTERMEDIARY-CARRIER DIRECTORY UPDATE

- Blue Cross of Kansas City - John Wilkie, President
- Blue Cross of Montana - Arvin Swenson, Medical Claims Manager
- Blue Cross of Utah - Reid Greenwood, Medical Coordinator
- Blue Shield of Kansas City - John Wilkie, President
- Aetna Life and Casualty, Seattle field office :
  Northgate Office Bldg.
  9750 Third Avenue, N.E.
  Seattle, Washington 98125
  Mailing Address: P.O. Box C25902
  Telephone: 206-527-4014
- Equitable Life Assurance Society of the United States
  Cheyenne, Wyoming field office:
  James Allison, Field Director and Medicare Coordinator
  Helen McCall, Administrative Manager
- Part B Medicare Claims Address for South Dakota:
  Medicare
  South Dakota Medical Service
  1601 W. Madison
  Sioux Falls, South Dakota, 57104

MEDICAID

New Medical Assistance Unit Directors

Bruce Ferguson - Washington
W. H. Kerns - Alabama
Peter Bloomsburgh - Illinois
Gerald F. Radke - Pennsylvania

New Single State Agency Heads

W. H. Kerns - Alabama
Bruce Ferguson - Washington
Jeffrey C. Miller - Illinois

Trainers...Take Note!

The Consultation and Training Branch of the Medicaid/Medicare Management Institute, in conjunction with the Audio-Visual Branch of the Social Security Administration, has produced a number of video-cassettes and 16mm training films for Medicare including:

- Introduction to Medicare: a discussion of the philosophy, functions and goals of the Medicare Program; 12-1/2 mins.
- Medicare and How it Works for You: an overview of the basic coverage aspects of the Medicare Program, especially helpful for use with beneficiaries; 29 mins.
- Completion of Form SSA-1490: designed for training SSA service representatives, but could also be useful in instructing Medicare beneficiaries in the proper completion of this document; 20 mins.
- Determination of Reasonable Charges: a clear and simple presentation of how Medicare decides what amount it will pay for Part B services; 8-1/2 mins.

All these 3/4" video-cassettes and films can be obtained from M/MMI and the HCFA Regional Offices. If you have any questions about the tapes or films, contact Wayne Gegorek (301)-594-8647, FTS 8-934-8647 in M/MMI.

The Institute is interested in knowing about training programs that have worked for you. You are invited to send copies of Medicaid and Medicare training curricula and publications to: Clearinghouse, HCFA/M/MMI, 389 EHR, 6401 Security Blvd., Baltimore, MD, 21235. Attention: Carlotta Wilkins. All materials will be catalogued. The Institute will incorporate a list of these training materials, along with names of appropriate contact persons, in an annotated bibliography scheduled for semi-annual publication.

We would also like to call your attention to the annual annotated bibliography published by the Income Maintenance/Medical Assistance Training Unit of the School of Social Welfare at the State University of New York at Albany. This publication catalogues many programs that are being used in Income Maintenance and Medical Assistance Training, on a State by State basis. For more information about this publication, contact Bill Waddell in the IM/MA Training Unit at SUNY (518) 455-6245.

DIRECT ADMISSION TO SNFs

In October 1977, the Medicare Bureau contracted with Blue Cross of Oregon and Blue Cross of Massachusetts to demonstrate whether waiver of the 3-day prior hospitalization requirement for coverage of extended care services affects the costs and utilization of inpatient (hospital and SNF) services under Medicare. The experimental procedures are identical to current Medicare procedures and regulations for SNFs except that the requirement that patients have an inpatient medically necessary hospital stay of at least 3 days prior to admission to SNF is waived. The demonstrations have been admitting patients about 18 months.

Central office staff will meet October 4-5 to discuss the experiences, early findings, issues, and implications of eliminating the prior hospitalization requirement on Medicare and Medicaid programs. For details, contact Elizabeth Cornelius, Office of Demonstrations and Evaluations, (301)-594-6414, FTS 8-934-6414.

MEDICAID STATE AGENCY ALERT

These Action Transmittals have been issued by HCFA in recent weeks. States desiring copies may order them by calling (301)-594-5519.

AT 79-62 Program Instruction 7/3/79
"Title XIX Social Security Act Sec. 1903(g) Utilization Control Validation Survey for Quarter ending June 30, 1979, in ten selected State mental hospitals"

AT 79-63 Reporting Requirements 7/23/79
"Change in reporting of sterilizations & hysterectomies"

AT 79-64 Preprint 8/3/79
"Suspension of practitioners convicted of crimes related to Medicare or Medicaid"

AT 79-67 Policy Clarification 8/9/79
"Medicaid QC policy on review of SSI-QA drops in non-1634 States"

AT 79-68 Program Instruction 8/14/79
"Identification of Medicaid quality control sample cases by substratum"

AT 79-69 Program Instruction 8/15/79
"Medicaid requirements for State programs of Early and Periodic Screening, Diagnosis, and Treatment of individuals under 21 - policy interpretation - program and penalty provision"

AT 79-70 Regulation 8/16/79
"PSRO Hospital Review - relationship of PSRO to hospitals and use of hospital review committees; norms for PSRO"

AT 79-71 Preprint 8/23/79
"EPSDT"

AT 79-74 Regulation 7/17/79
"Disclosure of information and access to provider records; requirements and conditions for participation"

AT 79-77 Preprint 9/15/79
"Preprinted State Plan Amendments on (1) required provider agreements, (2) disclosure of survey information and provider or contractor evaluation, and (3) disclosure of information by providers and fiscal agents"

AT 79-78 Program Instruction 9/7/79
"Title XIX Social Security Act revision of complete text of preprinted State plan"

CMS LIBRARY
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SHORT CLAIMS FORM PROPOSED

HCFA has tested a short form for Medicare medical insurance claims (Part B), designed to make things easier for beneficiaries. The new form spreads items from Part I of the standard HCFA-1490 in large type and with large blocks over a standard sized sheet of paper.

Results of the test in two Florida counties revealed that beneficiaries found the short form easier to complete; those who previously sought outside help with their claims were willing and able to complete the short form alone. When the procedure is initiated, the short form will be furnished beneficiaries with their notices of benefits for unassigned claims. Social Security offices will also have a supply of the forms.

If a common claim form is mandated for claims completed by physicians/suppliers, the short form 1490 will become the standard beneficiary form. Otherwise, the short form will be used at the Medicare carriers' option.

Medicaid Medicare Exchange

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Readers already on the mailing list for previous Exchange will receive the new MMX.

COMPLAINT AGAINST S.C. NURSING HOMES

The U.S. Justice Department filed a civil action on August 27, 1979 in Federal District Court in South Carolina against the South Carolina Health Care Association, charging the nursing home association with restraint of trade. The action stems from the association serving as the bargaining agent for member nursing homes in negotiating reimbursement contracts with the State Medicaid agency. Under this arrangement, the complaint alleges, restraint of trade occurs because State contracts with individual facilities are contingent upon establishing favorable contract terms for other facilities. This action contends that this arrangement has had the effect of eliminating competition among South Carolina nursing homes and that prices charged Medicaid by the nursing homes have increased. Attorney Stephen Cannon, of the Department of Justice's Anti-Trust Division is the contact person, at 202-633-2836.

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
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